Health Care Safety Net Administration



Management Update Report

Volume 1, Issue 2

July 2004

To increase access, assure quality, and improve health outcomes for the eligible uninsured residents of the District of Columbia.

From the DC Department of Health
Health Care Safety Net Administration

Contents

Letter from the Director

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Dear Fellow Stakeholders:

I hope you enjoyed the first (May) edition of the Health Care Safety Net Administration Management Update. In an effort to provide you with continuous information that is timely and informative, the updates will be developed on a bi-monthly basis. This July edition will highlight more program innovations for contract year 3 of the DC Health Care Alliance program and will help to inform you of the stages of development of this new and exciting patient-centered system of care for uninsured District residents.

As the healthcare industry changes, the DC Health Care Alliance program will be on the forefront of establishing the new paradigm in healthcare delivery. We will continue to incorporate progressive health care strategies to ensure positive long-term performance. These strategies will be highlighted in this issue and will demonstrate our course as we enter these new horizons.

Thank you for your continued commitment and support of the DC Health Care Alliance program.

Sincerely,

Brenda L. Emanuel, MPA
Director, HCSNA

The mission of the Health Care Safety Net Administration (HCSNA) is "to ensure that eligible uninsured residents of the District of Columbia are provided open access to condition appropriate, quality health care with an emphasis on disease prevention and community based primary care through an integrated, cost efficient, and culturally appropriate system."

PROGRAM GOALS AND STRATEGIES FOR SUCCESS OF THE HCSNA

In an effort to keep our stakeholders informed, below is a list of the key Health Care Safety Net Administration (HCSNA) program goals and strategies for improving health outcomes. The DC Health Care Alliance (Alliance) is much more than a program that provides for claims payment to medical providers', we are totally engaged in the development of a comprehensive approach to improving the health outcomes of Alliance members.

The provision of health services is but one component in a system to improve health outcomes. The HCSNA recognizes that improved health outcomes will come from the collective efforts of a health care system that is made up of health professionals, government officials, individuals and other institutions involved in producing health. We also recognize that to improve health, there must be a shift in focus and resources to prevention while maintaining high quality health care services.

HCSNA Program Goals

- To improve health outcomes of District residents
- To decrease inappropriate use of the ER and inpatient care
- To increase primary and preventive care and the use of the medical home model
- To create a coordinated patient-centered system of care and an adequate financial reimbursement strategy

Strategies for Improving Health Outcomes

- Establish an integrated system of comprehensive health care service providers: 6 hospitals, 44 clinics and over 800 primary and specialty providers
- Provide for access to care through maintaining the operations of 6 primary care clinics, one urgent care center, and an ambulatory care center
- Implement a care coordination initiative with hospitals, clinics and primary care settings
- Assign Alliance members to a Primary Care Provider (PCP) who acts as their medical home provider
- Initiate comprehensive patient education Initiative
- Initiate Low Priority Ambulance Transport Initiative
- Support Mayor's Ex-Offender Re-Entry Initiative
- Create a system for data collection and reporting that provides information on disease status, services provided, trends and cost of treatment
- Coordinate with DC Medical Homes Initiative for improved primary health care network
- Provide for closer monitoring of inpatient care pre-authorization process, disease management program and ER use
- Institute a provider incentive program

ALLIANCE MEMBERSHIP

A major question that DC Health Care Alliance stakeholders have is whether the Alliance is enrolling eligible District residents into the program. The HCSNA is conducting an ongoing audit of the Alliance membership to ensure that the Alliance program enrollment process meets the following criteria 100% of the time: *(Due to the practice of presumptive eligibility, some members may not meet all of the eligibility criteria.)*

- Enroll District residents only
- Enroll District residents who have no form of medical insurance coverage
- Enroll residents who's income is at or below 200% of the FPL only
- Does not enroll persons who are enrolled in Medicaid
- Does not enroll persons who are eligible for Medicaid

Below is a table that provides a summary of the Alliance membership through 5/20/04. As of 5/20/04, there were 25,816 persons enrolled in the Alliance. This table provides a breakdown of the data by adult members without children, adult members with children and children without an adult member.

Summary of Alliance Membership

Adults without Children	**24564**
Children linked to Adults	**607**
Members Under Age 19 not linked to an adult	**2**
Adults linked to Children	**565**
Under Age of 19 in Dept of Corrections Custody	**59**
Under Age of 19 in Metropolitan Police Dept Custody	**19**
Total Membership	**25,816**
Total Children *in the Program (Under the Age of 19)*	**687**

Source: CHP Membership as of 5/20/04

The main distinction between the Medicaid program and the Alliance program is that the majority of the Alliance membership, 24,564 (95%) are adults without children. These individuals are not eligible for Medicaid. There is however a Medicaid category for disabled persons with or without children. Chartered Health Plan, which is the organization that manages the enrollment process for the Alliance, has a rigorous system in place to identify individuals who may be eligible for Medicaid due to a disability. During the initial screening specific questions are asked relating to the applicant's health status to ascertain whether the applicant has a disability and should be referred to Medicaid. If the applicant indicates that they have a disability, then they are referred to Medicaid to request a medical exam report. Medicaid uses the medical exam

report to determine the disability and Medicaid eligibility status of the applicant. The Alliance identifies this individual in a Medicaid pending status until the Medicaid disability and eligibility decision is rendered.

In addition, there are 565 adults who have children enrolled in the Alliance. These are adults who have immigrant status and are therefore not eligible for Medicaid. There are also 59 persons under age 19 who are in custody of the Department of Corrections, and as such are not eligible for Medicaid due to their incarceration. The Alliance provides medical services to individuals in the custody of Metropolitan Police Department (MPD.) There are 19 persons under age 19, who were in the custody of the Metropolitan Police Department (MPD) as of 5/20/04.

The HCSNA through its contractor Gardiner, Kamya and Associates (GKA), is conducting a monthly verification of enrollment. In this audit process, GKA will do random sampling of the enrollment database to ensure that all enrollment documents are on file, and will verify that the members were not enrolled in Medicaid on the date of service in question. The HCSNA is also working with the Office of the Chief Technology Officer to use the Single Point of Entry Process as a means for determining if the Alliance is enrolling persons who are eligible (and not enrolled) in Medicaid. It is important to note that the District cannot force an individual to complete a Medicaid application. Enrollment in Medicaid is a voluntary process.

These statistics give us assurance that the current Alliance enrollment process is working and the District's funds are protected.

PHYSICIAN ADVISORY COUNCIL

The HCSNA has the responsibility to provide oversight, monitoring and management for the care provided to Alliance members. As the HCSNA staff began to implement monitoring systems, it was determined that an advisory group would be an asset to the success of the operations of the Alliance program. In the later part of the summer 2003, the clinical team under the direction of the Director of the Health Care Safety Net Administration developed and distributed a letter to physician volunteer representatives to several organizations requesting a physician representative to volunteer to serve on the HCSNA Physician Advisory Council.

The meetings were scheduled quarterly and the first meeting was held in October 2003 and are scheduled quarterly. The council approved the mission, objectives and meeting schedule. The mission of the Physician Advisory Council is "to advise the Health Care Safety Net Administration and the DC Health Care Alliance provider network in the implementation of process and measures that will improve the quality of care for Alliance members."

The following objectives were established:

- To review the minutes and other documents provided by the Quality of Care subcommittee to provide strategic direction and input;
- To review policies and procedures related to the clinical aspects of the HCSNA;
- To recommend development of policies and procedures as appropriate;
- To review the quality-related reports produced by various vendors affiliated with the Alliance program; and
- To advise the HCSNA and the Alliance provider network on quality concerns.

The Physician Advisory Council has proven to be a benefit thus far in providing advise in the following areas:

- Advise on the indicators of the annual focus study that is presently being conducted by the Administrative Service Organization (ASO) for the DC Health Care Alliance;
- Advise on the expansion of the benefits package for Alliance members;
- Some of the HCSNA future plans that will require input from the Physician Advisory Council are the development and implementation of the HCSNA Utilization Review Committee and;
- Review and advise on the results from the emergency room study conducted by the External Quality Review Organization (EQRO),
- Review of the results of the focus study and input on what should comprise the next focus study.

This Council is presently open to membership and welcomes the expertise of additional physicians. For information on how to obtain membership in the Physician Advisory Council, please contact Paula Johnson at (202) 442-5819 or (202) 442-5961.

URGENT MATTERS INITIATIVE

Annual Meeting Update

By Brenda Emanuel

I had the pleasure of being invited to attend the annual meeting of the Urgent Matters Initiative that was held on May 26, 2004. Urgent Matters is a national initiative of the Robert Wood Johnson Foundation and is being directed by the George Washington University Medical Center. The program was developed to access the nations' safety net while looking at a critical component of the system: overcrowded emergency room departments.

Ten communities across the country were assessed to examine the variables that shape the health care networks available to the uninsured and underinsured populations. A report was developed on each community that includes

an estimate of the use of the emergency department for care that could safely be provided in a primary care setting. The findings from the reports were presented at this annual meeting. Members of the ten community hospitals in the Urgent Matters initiative gave the presentations. Individuals such as Dennis O'Leary, MD, President of the JACHO and Robin Weinick, PhD, Senior Advisor for Safety Nets and Low-Income Populations, Agency for Healthcare Research and Quality gave other remarks. The presentations along with the reports contain common characteristics of communities, opportunities and challenges for safety net hospitals and strategies for improving care for uninsured and underserved residents.

The ten* Urgent Matters *Hospitals are as follows:

1. *Atlanta, Georgia - Grady Health System*
2. *Boston, Massachusetts - Boston Medical Center*
3. *Detroit, Michigan- Henry Ford Health System*
4. *Fairfax County, Virginia - Inova Fairfax Hospital*
5. *Memphis, Tennessee- The Regional Medical Center*
6. *Phoenix, Arizona- St. Joseph's Hospital and Medical Center*
7. *Queens, New York- Elmhurst Hospital Center*
8. *San Antonio, Texas- University Health System*
9. *Lincoln, Nebraska- BryanLGH Medical Center*
10. *San Diego, California- University of California*

The meeting was very exciting and informative. All the issues we hear in the District of Columbia from our Alliance member hospitals were expressed and presented at this annual meeting. There were collective lessons learned and strategies presented for improvement by these hospitals that could be of great benefit to District of Columbia Hospitals. I asked the Director of this project, Dr. Bruce Siegel, MD, MPH, how he intends to share this information with the rest of the world. The Urgent Matters National Advisory Committee is developing a newsletter and will have web casts that will inform the nation of the findings of this initiative. In the meantime, the following is a summary of the recommendations from the annual report.

Key Findings and Strategies for Improving Care for Uninsured and Underserved Residents

Safety Net Structure and Financing

- Even the most comprehensive and traditionally robust safety nets are facing financial challenges and feeling the effects of the safety net paradox: as the need for safety net services grows, the ability and willingness of governments to support these services diminishes.
- About one-third of residents in Urgent Matters communities are either uninsured or covered by Medicaid or the State Children's Health Insurance Program (SCHIP) and are likely to turn to the safety net for their health care needs.
- Communities differ substantially in terms of the size and scope of their safety nets. State and local financing for safety net services are considerable in some communities and minimal in others.
- With fewer resources available to support safety net services, all of the communities that are described in this report are being required to do more with less. They are facing cutbacks in payments for direct services and/or decreasing subsidies from state or local governments. All the while, demand for care continues to skyrocket. This is not a strategy that can be sustained over time.

Availability of Safety Net Services

- After conducing assessments of the ten Urgent Matters communities, we have concluded that the availability of primary care is relatively high, specialty care is strained, behavioral health care is generally quite limited, and dental care is virtually non-existent.
- The accessibility of primary care services appears to relate directly to the availability of both dedicated funding streams and substantial systems or network of providers that serve vulnerable populations.
- The emergency department (ED) was ranked "high" on availability in all 10 communities. Despite long waits for care, patients find the convenience and accessibility of the ED a better alternative to months-long waits for specialty care and multiple visits for diagnostic tests and procedures.
- Important and encouraging initiatives have been implemented by a number of communities to integrate services and patient information across safety net systems. These programs will ultimately improve service delivery and access to care for uninsured and underserved community residents.

Focus Group Discussions with Community Residents

- Focus group participants are very appreciative of the care they receive from safety net facilities. Most say that the care is high quality and they rely heavily on these services for their health care needs.
- Nearly all participants stated that they have difficulties accessing specialty care, behavioral health and dental care.
- Participants lack information about affordable options for health care and are often not aware of the availability of safety net services in their communities**.**
- Focus group participants complained about long waits at many safety net facilities, although they generally understood that services were in high demand. They were more concerned with poor treatment from providers and staff at safety net hospitals and clinics than they were with long waits

for care.
- Lack of adequate interpreters or culturally competent providers creates significant obstacles to accessing services. Transportation also serves as a barrier to care in many of the communities.

Emergency Department Use

- A significant percentage of visits to Urgent Matters emergency departments could have been treated in settings other than the ED. Over one-fifth (21.4 percent) of ED visits across the hospitals were non-emergent and another 20.6 percent were emergent but primary care treatable. Thus, four of ten ED visits that did not result in an inpatient admission could have been safely treated outside of the ED.
- EDs at Urgent Matters hospitals see large numbers of uninsured and publicly insured patients. About 60 percent of emergency department visits were for patients who were either uninsured or covered by Medicaid or SCHIP. These hospitals also see a very diverse patient population. About one-fifth (21.2 percent) of visits were for patients who are white, two-fifths (41.8 percent) were for African-American patients, and one-quarter (24.5 percent) were for Hispanic and Latino patients.
- The rates of use of the ED for primary care treatable visits were higher than the rate for emergent, non-preventable visits. For every visit that was in the emergent, non-preventable category, there were two non-emergent visits and another two emergent but primary care treatable visits. Rates were higher for patients covered by Medicaid and for African-American and Latino or Hispanic patients.
- Rates for ED usage for primary care treatable conditions are far higher for children than for adults or elderly patients. For every visit by a child that was emergent and non-preventable, there were 3.74 non-emergent visits, and another 3.85 emergent primary care treatable visits.
- The availability of alternative sources of care does not appear to explain the use of the ED for primary care treatable conditions. Across all sites, patients used the ED for primary care treatable conditions at relatively comparable rates during the hours of 8:00 am to 4:00 pm, when clinics and private practice providers are open then in the hours of 4:00 pm to midnight.

Strategies for Sustaining The Safety Net

Below is a brief summary of the strategies as recommended by the Urgent Matters Safety Net Assessment Team:
- Communities need to clearly understand the impact of changes in public financing on safety net services, including the impact on access to care for the most vulnerable populations.
- Safety net providers, community health workers and case managers should work together to measure existing capacity of safety net systems to identify areas needing expansion and better execution.
- Collaboration among existing safety net providers should be encouraged and developed as a way of increasing overall capacity and improving quality of care for uninsured and underserved populations.
- Safety net providers should implement information systems that follow patients across systems and sites of care, allowing providers to share patient files across various sites of service.
- Hospitals and other safety net providers should develop formal referral networks to improve access and outcomes for patients who present at the ED with primary care treatable conditions but who have no medical homes.
- All hospitals in the Urgent Matters communities should conduct an analysis of the use of their emergency departments for emergent and non-emergent care.
- Given the increasing diversity of the population in many of the Urgent Matters communities, safety net providers must develop programs to provide language services, health education, and culturally appropriate outreach that effectively meet the needs of the population.
- Public awareness campaigns and outreach efforts should be employed to help uninsured and underserved residents learn how to navigate the health care system.
- Key stakeholders should make concerted efforts to include more Latinos, African Americans and members of other racial and ethnic groups, in all aspects of the decision-making process.
- The effectiveness of bus routes and the transportation systems serving low-income, underserved populations should be evaluated in communities.

For more information on the Urgent Matters initiative you may go to www.urgentmatters.org. There are two web casts scheduled in the month of July on 1st and 22nd, to register visit Urgent matters website. The Health Care Safety Net Administration will include more information on the Urgent Matters Initiative in future editions of the Management Update.

DEPARTMENT OF CORRECTIONS CARE COORDINATION

The purpose of the Care Coordination Initiative for the Department of Corrections (DOC) is to facilitate the transfer of vital health information and to coordinate care for pre-released inmates in an Integrated Care Center (ICC) to ensure access to care, at the appropriate location.

Care Coordination is a collaborative process, which assesses, plans, coordinates, implements, monitors and evaluates the needs of pre-released inmates using community based primary care to improve the health outcomes of released inmates.

There are several objectives that the DOC and Health Care Safety Net Administration (HCSNA) are striving to accomplish, such as:

- Coordination of health care prior to release from DOC will ensure that eligible released inmates have access to condition appropriate primary care;
- Increase utilization of preventative health care by released inmates through health education and preventative screening;
- Refer inmates with chronic diseases to case/disease management upon release from DOC;
- Reduce the use of emergency rooms as a medical home/PCP and coordinating health care for inmates reintegrated into the community via halfway houses.

This initiative can lead to several benefits with the ultimate goal of a healthier society with positive outcomes. Some benefits are:

- Each inmate with a scheduled release date will be given an opportunity to complete the alliance application;
- Pre-release screening allows opportunity for referral to disease/case management;
- Inmates released without prior notification are informed of the ICC walk-in policy.

During the release process, care is centralized in an ICC and released inmates will not have to depend on the Emergency Care Center (ECC) for primary health care.

DELMARVA

To accomplish our mission to provide open access to condition appropriate, quality health care with an emphasis on disease prevention, an external quality review organization, the Delmarva Foundation, was awarded a contract on May 1, 2004. The Delmarva Foundation is a non-profit organization dedicated to improving healthcare quality. The contract with Delmarva will allow the HCSNA to validate the quality of care received by Alliance members.

The Delmarva Foundation's new contract with the HCSNA calls for the development of a quality-monitoring program, which will include hospital and clinic retrospective reviews. A monthly sample of hospital discharges will be reviewed to determine if the admissions were appropriate and that professional standards of quality care were met. The systems utilized by Unity Health Care Inc. in the management of the six former Public Benefit Corporation (PBC) clinics, now known as the Unity clinics, will be reviewed to evaluate the systems utilized and the quality of care provided to patients. Delmarva will also conduct a special study of emergency department usage to identify the quality of care provided to analyze access issues and determine the appropriateness of the emergency department visits.

ADVANCED PHARMACY CARE SERVICES UPDATE

After Hours Prescription Program

One of the concerns identified as a barrier to care by the provider network was the inaccessibility of pharmaceuticals to Alliance members after being discharged from the emergency room. The After Hours Prescription Program, a pilot program for 90-day trial period, was implemented in April 2004. The program is intended to provide only the critically necessary medications to Alliance members, when the Alliance pharmacies are closed and when it has been clinically determined that the patients cannot wait until the pharmacies are open. The 90-day pilot program will provide access to pharmaceuticals for Alliance members that have received emergency care after normal business hours. However, the program is not intended for the routine filling of chronic or non-urgent medications. The success of this pilot study would alleviate or decrease delays in treatment, specifically, the initiation of therapeutic treatment until follow-up care with the Primary Care Physician/Medical Home can be arranged. Additionally, this could decrease the return of patients to the emergency room for treatment due to the inability to obtain the prescribed medication.

As of April 30, 2004, a total of fifty-six (56) prescriptions were presented to CVS Pharmacy (After Hours Prescription Program Provider participant). Thirty-seven (37) of the fifty-six (56) prescriptions (66%) presented were filled at a cost of $361.88. The average cost per prescription was $13.51. Nineteen (19) of the fifty-six (56) prescriptions (44%) were denied because the prescriptions did not meet the criteria established for the program.

COORDINATED EFFORTS WITH APRA

The Department of Health, (DOH), Addiction, Prevention and Recovery Administration (APRA), and the Health Care Safety Net Administration (HCSNA) have entered into a collaborative effort involving the Access to Recovery Grant from Health and Human Services (HHS), Substance Abuse and Mental Health Administration (SAMPSA). This grant is expected to be awarded for the fiscal year 2005. The funding will be used to place four (4) APRA intake coordinators in specified DC Health Care Alliance Clinics. The intake coordinators will be integrated and work in close cooperation with the staff of the health clinics. The intake coordinators will provide direct substance abuse assessments and referrals for substance abuse treatment. The clinic personnel will continue to provide their usual services including a history, physicals and necessary testing for eligible clients. This endeavor will add significantly to identification and treatment efficacy of the referral process since the Alliance does not cover substance abuse treatment.

FINANCIAL UPDATES

Annual Payment Reconciliation Services

The HCSNA completed its annual payment reconciliation services for the Alliance program for contract year 2. Gardiner, Kamya & Associates, conducted the reconciliation. The purpose of the reconciliation is to validate all payments made to the providers with respect to the terms and conditions of the contract, between the HCSNA and the Alliance partners. The report showed significant improvements in the operations since contract year 1. The Alliance program has demonstrated and sustained the following improvements since its inception:

- Reconciled and continues to recover overpayments made to providers;
- Improvements in the eligibility screening process, which has resulted in the disenrollment of Medicaid eligible patients
- Expanded coverage from 14,000 members to approximately 21,000 members;
- Successfully negotiated a two-year contract with its partners; and
- Streamlined the operations of the Alliance program while instituting several measures to evaluate and audit the administrative and access maintenance costs paid to providers.

The HCSNA, while still in its formative years, has created the infrastructure that will make access to care available to the "eligible uninsured" residents of the District of Columbia. The program continues to be a catalyst in the integration of health care services to the indigent population.

Medicaid Recoupment

The HCSNA has been successful in recouping Alliance payments made to providers for members who were enrolled in Medicaid. The next management update will provide a summary of the funding recouped to date.

ALLIANCE STATISTICAL DATA

Below are the annualized projected numbers of visits and/or persons served through the DC Health Care Alliance $96 million dollar contract:

21,000 average annual Alliance member enrollment
4,000 Inmates of the Department of Corrections
71,566 DC Public School Children
95,490 visits made to former PBC clinics per year (number served includes Alliance members, Medicaid, other third party, self-pay and others).

- Anacostia- 16,226 visits
- Congress Heights- 14, 771 visits
- Hunt Place- 17,475 visits
- Southwest- 16,658 visits
- Walker Jones- 21,203 visits
- Woodridge- 9,157 visits

11,325 visits to the Urgent Care Center on DC General Health Campus per year (number served includes Alliance members, Medicaid, other third party, self-pay and others).

46,304 visits to the Ambulatory Care Center on DC General Health Campus per year (number served includes Alliance members, Medicaid, other third party, self-pay and others).

Current Alliance Enrollment as of June 1, 2004:

Fully Enrolled	**22,487**
Presumptively Enrolled	**1,098**
Department of Corrections	**2,175**
Halfway House	**150**
Metropolitan Police Dept.	**282**
Medicaid Pending	**184**
SSI Pending	**4**
Totals	**26,380**

Source Data: *Chartered Health Plan Member Database*

ANNOUNCEMENTS

1. Operational Oversight Committee – *4th Thursday each month*
2. Alliance Members Advisory Council – *Monthly (TBD)*
3. Capital Improvements Subcommittee – *Quarterly as needed*
4. Information Technology Subcommittee – *3rd Tuesday each month*
5. Data Reporting Subcommittee – *2nd Wednesday of each month*
6. Quality of Care Subcommittee – *2nd Friday of each month*
7. Care Coordination Committee - *Monthly*
8. Emergency Room Ad Hoc Committee – *3rd Thursday of each month*
9. Physician Advisory Council – *Quarterly (2nd Wednesdays)*
10. Risk Management Ad Hoc Committee – *Monthly (TBD)*
11. Committee on Persons In Custody - *Quarterly*
12. Utilization Review Committee – *4th Thursday of each month*
13. Patient/Provider Satisfaction Subcommittee – *Monthly (TBD)*

TESTIMONIAL

"My health insurance had recently expired and I was in need of medical services. I went to the Walker Jones clinic, and found out about this wonderful new medical plan called the DC Health Care Alliance that is available to DC residents who are qualified. Upon my enrollment, I have received extremely good medical services from extremely astute primary care physicians to excellent specialty care treatment. When a DC resident is down on his or her financial situation, it is truly a blessing that the DC government will not let its citizens slip into medical disarray." **William Foster, Alliance Member.**

Government of the District of Columbia
Anthony A. Williams, Mayor

GOVERNMENT OF THE DISTRICT OF COLUMBIA
DEPARTMENT OF HEALTH

Brenda L. Emanuel, Director
Health Care Safety Net Administration

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